

Winston Day Camp
Parent Form
INSURANCE INFORMATION

CAMPER: _____ DATE OF BIRTH: _____ SS# _____

FAMILY MEDICAL/HOSPITAL INSURANCE NAME: _____

CERTIFICATION NUMBER: _____

GROUP NUMBER: _____

CARRIER ADDRESS: _____

NAME OF INSURED: _____

PLEASE ATTACH A COPY OF INSURANCE CARD
FRONT AND BACK
TO THIS FORM

In the event that your camper needs to have medication that is not stocked in our camp infirmaries, the following information is mandatory for you to be able to use any drug plan:

All pertinent information will be given to the pharmacist

1. Please attach a copy of your PRESCRIPTION CARD, FRONT AND BACK, to this form.

2. Camper's Name: _____ Date of birth: _____

Family Name: _____

Address: _____

Telephone Number: _____

3. Amount of Co-Pay: \$ _____

4. Medication allergies: _____